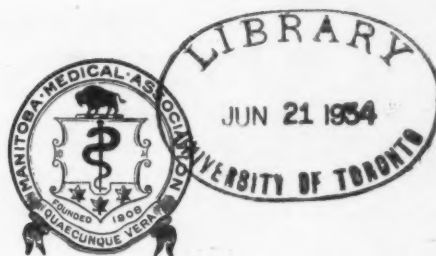


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The Manitoba Medical (Association) Review



IN AFFILIATION WITH
THE CANADIAN MEDICAL ASSOCIATION
THE BRITISH MEDICAL ASSOCIATION

JANUARY - FEBRUARY

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VOL. XIV. NO. 1^{1/2}

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Manitoba Medical Association



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The Manitoba Medical Association Review

Formerly the Bulletin of the Manitoba Medical Association
See Page 19

JANUARY - FEBRUARY, 1934

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Editor—C. W. MacCHARLES, M.D. (Man.)
Medical Historian—ROSS B. MITCHELL, B.A., M.D., C.M. (Man.), F.R.C.P.(C.)

*Editorial or other opinion expressed in this Bulletin is not necessarily
sanctioned by the Manitoba Medical Association.*

Cerebral Arteriosclerosis

By

A. T. MATHERS, M.D., C.M. (Man.), F.R.C.P. (C.)

*Dean of the Faculty of Medicine and Associate Professor of Medicine
University of Manitoba*

INTRODUCTION

Examination of mortality and morbidity tables as compiled by Life Insurance companies and governments in English-speaking countries shows that during the past few years there has been a striking increase in the incidence of the so-called degenerative diseases, such as chronic heart and kidney disease, arteriosclerosis, etc. The increase is certainly sufficient to attract attention. It may be that it is partly due to the fact that diagnoses of this kind are more accurately made than formerly, but clinical experience and consideration of the character of modern life, convince one that there is without doubt an actual and absolute increase in these conditions. That they rank so high as causes of mortality and morbidity is sufficient reason for our re-directing our attention to them. It is imperative that we survey afresh the whole question of cardio vascular disease—cast out the time-worn and useless doctrines that rest upon no better basis than traditional belief.

It might be well to confine our attention to one of the many aspects that are interesting and enticing. The consideration of cerebral arteriosclerosis as a chronic disease picture may be useful. In this hurried review there is no intention of touching upon the sudden destruction of nervous tissue by hæmorrhage or the more gradual but extensive damage that comes from thrombosis. What we are interested in are the signs and symptoms produced by diffuse disturbance of nutrition of the central nervous tissues consequent upon alteration in their blood vessels. The

picture or pictures produced, while common enough, seem to be too lightly regarded.

SYMPTOMS AND DIAGNOSIS

Spending no time upon what is likely to be an unsatisfactory discussion of the etiology of vascular disease in general, we might pass at once to the consideration of the clinical picture itself.

The first noteworthy point is that a large number of these patients present themselves with symptoms suggestive of the neurasthenia symptom complex, and it is to this category that they are so frequently and finally consigned. That there is a true neurasthenia will be granted, but that the term has been grossly abused will also be granted. No neurasthenia occurs without some definite etiological preceding condition that will generally be revealed by a consideration of the history. Constitutional neurasthenia yields evidences of its presence, traceable to early youth, while the acquired variety results from a combination of fatigue in any direction with the chronic action of overwrought emotions. "Nervousness," using the term in its broad sense, appearing without apparent cause in a person of middle age or beyond, should direct our attention at once to the vascular system.

It is well to remember, too, that even in the inveterate constitutional neurasthenic, arteriosclerosis is likely to appear early.

In passing, I would remind you of the work of CANNON. You will recollect that his re-

searches have shown how strong emotion is accompanied by many interesting bodily changes such as mobilization of sugar from the liver, rise in blood pressure, changed distribution of blood and increased, coagulability. Coincident with these there is apparently a definite pouring out of adrenalin. That arteriosclerosis can be produced experimentally in rabbits by repeated injection of adrenalin and that neurasthenics are constantly subjected to the play of emotion, suggests a reason why they early show evidence of blood vessel degeneration.

One of the noteworthy points then in the symptomatology of cerebral arteriosclerosis is this *pseudo-neurasthenia* accompanied often enough by loss of weight and color.

HEADACHE is another extremely common complaint. Frequently the story is that, beginning as a sense of pressure or heaviness in the head, it increases in intensity throughout the day. Mental effort is particularly likely to aggravate it and the French with their apt method of describing clinical points, have called this the *symptom of painful thinking*. To believe all headaches occurring at the "arteriosclerotic" age to be due to the vascular change would, of course, be foolish, but suffice it to say that *headache* is a common complaint in those afflicted with this condition.

Then, too, the patient often complains of *light headedness*. This, you will find, on close inquiry, to include not only actual dizziness, but also sudden weak feelings, momentary darkening of the visual field, or even feelings of anxiety. Actual severe dizziness in which the patient or his environment apparently revolve, seems to be rare. In any case these feelings give rise to a good bit of anxiety in the patient.

Noteworthy too, is the phenomenon of *sleep inversion*. By this we mean a tendency to drowsiness by day and a distressing wakefulness or light disturbed sleeping at night. In fact, the patient's initial complaint may be sleeplessness or perhaps a tendency to waken very early in the morning.

Abnormal sensations, such as formication, prickling, limbs going to sleep, are frequently complained of.

At the same time, severe *attacks of pain* located chiefly in the limbs, but occasionally in the trunk and even in the distribution of the fifth nerve, may be mentioned.

Certain *disturbances of motor function* are present, although often not spontaneously complained of. Questioning brings out the fact that walking or going upstairs, at first normal, painless and unhindered, in a certain time is accompanied by a sensation of extreme weakness in the legs with cramping—the whole thing con-

tinuing until further progress becomes impossible. After a short rest, the trouble disappears, only to recur after exertion. Some of this disturbance is no doubt peripheral in origin, but in other cases there seems little doubt that the vascular spasm is in the spinal cord itself, since at the time of distress one can at times establish a definite increase in the deep tendon reflexes and occasionally a definite Babinski reflex.

Corresponding to these spinal phenomena are the *transitory paresis* of an arm or leg or perhaps a passing motor aphasia—all of which we trace to disturbance in the Cerebrum and all lying on the borderland of actual organic destruction.

The brain substance, when microscopically examined, shows a multiplicity of small unapparent losses varying in size from what might be called miliary to the size of a pea, irregular in outline and lying in circumscribed areas chiefly in the cerebrum, mid brain and region of the corpus striatum. Such "Lacunae" as they are called are apparently not due to a simple process of softening consequent upon arterial occlusion since the vessels are not completely closed.

The occasional *hemiplegia* coming on in elderly people and not accompanied by the spectacular features of hæmorrhagic apoplexy—the slow attack with retained consciousness—seems to have a definite connection with this formation of lacunae. The characteristic thing is that the hemiplegia is of slow onset and generally clears up completely only to recur later. Certain other features now appear—finer movements of the hands are interfered with and the gait becomes definitely altered, the fully developed picture being strongly suggestive of Parkinson's disease and no doubt like it, due to lesions in the region of the corpus striatum.

A clinical picture suggestive of bulbar palsy is common and late in the disease incontinence develops.

Some of the most striking *alterations occur in the psychical field*. Among the men of middle life or beyond, who come to consult us, we are confronted by men who show gradual but striking psychical changes. Their memory plays them false—they forget names, words do not come readily when wanted and careful testing out of the memory for past and recent events shows a peculiar combination of particularly clear retention of many particulars and complete loss of others—an insular amnesia—*islands of memory loss*.

We are all conscious of the possession of a certain mental tension or alertness—in the cerebral arteriosclerotic there is a definite let down in this. They are no longer so alert—they make little blunders throughout their daily lives and do not notice them—they become a little careless about themselves.

A certain prodigality in the outward evidences of emotion is also noteworthy. Crying spells are common. The cause of the outburst may be nothing that would ordinarily produce grief at all, or it may be something that, when well, the patient would pass over with only a transient feeling of sorrow. The injury of a dog in the street will evoke a flood of tears when misfortune to the patient's own family brings none.

The nucleus of personality remains however. These patients easily elicit our sympathy. We have a kindly feeling toward them—our "empathic index" for them is high: we do not feel the repugnance for them that appears when we are confronted by certain other types of mental failure.

Careful research generally reveals other evidences of gradual vascular degeneration. Heart, kidneys, etc., bear the marks of the disease. Often enough the peripheral vessels accessible at wrist or temple, show no marked hardening. One must not be misled by this—local changes in blood vessels are common and in one's own experience cerebral alteration without radical change elsewhere is frequent. Ophthalmoscopic examination, which everyone should be able to do, reveals in these cases well marked changes in the retinal vessels, and since the retina is specialized cerebral tissue, one may judge from the condition of these retinal vessels, just what the condition of vessels further back is. The changes one should particularly look for are: a narrowing and irregular calibre of the arteries (easily distinguished by their color) increased tortuosity and apparent "cutting off" of the veins where arteries cross them.

TREATMENT

In speaking of treatment we at once grant that little or nothing in the way of actual retrogression of disease or reparation of damaged tissue can be expected. It is possible that, by virtue of certain measures, the progress of the disease may be slowed down and the patient granted, at least, a temporary extension of life with comparative comfort.

The value of psychotherapy must not be overlooked. In this, as in other organic diseases, we are too liable to adopt an attitude too much influenced by hopelessness and helplessness. Occasional talks in which reassurance and comfort to the patient are prominent, help wonderfully in dispelling fear. Fear is indeed a deadly emotion and all measures calculated to dispose of it are worthy of trial. Death, or disablement from "stroke" and serious impairment of the mental faculties seem to be the chief bugbears of these patients. Reassurance and proper hygienic measures seem to be capable of holding off these unfortunate occurrences.

It is important that rest and physical relaxation for an hour after meals and for at least nine hours at night, be insisted upon. Moderate exercise in the open air once or twice daily after the rest should also be advised. Any tendency toward invalidism as well as tendencies toward too strenuous exertion, should be consistently combated.

In the matter of diet, care in the avoiding of over-eating rather than a meticulously selected diet, should be the aim. Salt free diet, is commonly advocated. There seems no reason why a small amount of meat should not be allowed, provided constipation is safeguarded against.

The nervousness and apprehension at times exhibited, often respond well to small repeated doses of bromide (*e.g.* 12-15 grains t.i.d) or to doses of one-quarter to one-third grain luminal t.i.d. The latter may well have one-quarter or one-third gr. Phenolphthalein added to it. Occasionally, difficulty in getting to sleep will require attention, and in such instances warm baths at 96-98 degrees for one-half hour or hot foot baths at bedtime will meet the needs. From time to time some of the usual hypnotics may be required and Veronal or Luminal with hot drinks seem most useful.

For many years potassium iodide has been given in this type of case. One suspects that custom and tradition rather than proven worth have been the chief factors in the continued popularity of this drug. Certain it is that results from its exhibition are decidedly meagre—probably not more than could be accounted for by other measures in use.

What Every Woman Doesn't Know—

How to give Cod Liver Oil

Some authorities recommend that cod liver oil be given in the morning and at bed time so as to assure an appetite for the oil, while others prefer to give it after meals in order not to retard gastric secretions. If the mother will place the very young baby on her lap and hold the child's mouth open by gently pressing the cheeks together between her thumb and fingers while she administers the oil, all of it will be taken. The infant soon becomes accustomed to taking the oil without having its mouth held open. Mead's Newfoundland Cod Liver Oil, of minimum acidity and prepared from fresh healthy livers, is well tolerated by infants and children and is palatable without flavoring.

If given cold, cod liver oil has little taste, for the cold tends to paralyze momentarily the gustatory nerves. As any "taste" is largely a metallic one from the silver or silver-plated spoon (particularly if the plating is worn), a glass spoon has an advantage.

Mead's 10 D Cod Liver Oil is made from Mead's Newfoundland Cod Liver Oil. In cases of fat intolerance the former has an advantage since it can be given in 1/3 to 1/2 the usual cod liver oil dosage.

Jubilee of Manitoba Medical College

CLINICAL WEEK—MAY 14th to 19th, 1934

The Jubilee of Manitoba Medical College will be observed in Winnipeg during the week of May 14th to 19th, 1934, with a clinical week. The other Canadian Universities are being invited to send representatives, who will contribute to the programme, and in addition a prominent clinician, probably from the United States, will be present. Further announcements along this line will be made in later issues of the *Bulletin*. The aim of the committee in charge of arrangements is, not only to mark fittingly the completion of fifty years of teaching in Manitoba Medical College, but also to provide a clinical programme which will appeal to medical men, particularly in the Western Provinces. The College of physicians and Surgeons of Manitoba has kindly given a grant to help defray the cost of the undertaking, but in order to meet all expenses a registration fee, probably of ten dollars, will be required.

One of the most valuable features of the week will be the small clinical groups, in which the clinician and group of twelve to fifteen doctors will discuss in intimate fashion the technique, methods and difficulties of various clinical procedures.

The following is the tentative programme:

Monday, May 14th

- 9.00-12.00 Registration—Manitoba Medical College.
- 11.00-12.00 Moving Picture—"Infections of the Hand."
- 12.30- 2.00 Lunch—Clinical Address.
- 2.30- 5.00 Fractures—Dr. H. P. H. Galloway, Chairman
 - (1) Immediate Care of Fractures and Transport of Patient.
 - (2) Methods of Applying Traction.
 - (3) Fractures of the Elbow in Children.
 - (4) Fracture of the Neck of the Femur.
 - (5) The Value of Non-Padded Plaster Casts.
- Evening Ceremonial Meeting and Reception—Winnipeg Auditorium. Address: Progress of Medicine in Fifty Years.

‡ ‡ ‡ ‡

Tuesday, May 15th

- 9.00-11.00 Clinical Pathological Conference—Dr. C. R. Gilmour and Prof. Wm. Boyd.
- 11.00-12.15 Small Group Clinical Demonstrations and Discussions.
- 12.30- 2.00 Lunch—Clinical Address.
- 2.30- 5.00 Surgical Emergencies—Dr. B. J. Brandon, Chairman.
 - (1) Treatment of Head Injuries.
 - (2) Diagnosis and Treatment of Abdominal Injuries.
 - (3) Emergencies of Upper Abdomen.
 - (4) Late Appendicitis.
- 8.30 Scientific Meeting—Guest Speakers.

Wednesday, May 16th

- Morning University of Manitoba Convocation, Winnipeg Auditorium.
- Afternoon Clinical Lectures—Medicine and Surgery.
- Evening Alumni Dinner and Dance.

‡ ‡ ‡ ‡

Thursday, May 17th

- 9.00-11.00 Tumour Clinic—Prof. Wm. Boyd, Chairman.
 - (1) Grading of Malignancy; Its Bearing on Treatment.
 - (2) Lip and Oral Cancer.
 - (3) Cancer of Breast.
 - (4) Enlarged Lymph Glands of the Neck.
- 11.00-12.15 Small Group Clinical Demonstrations and Discussions.
- 12.30- 2.00 Lunch—Clinical Address.
- 2.30- 5.00 Functional Disorders of the Nervous System. Dr. Chas. Hunter, Chairman.
 - (1) Manifestations.
 - (2) Aetiology.
 - (3) Management.

‡ ‡ ‡ ‡

Friday, May 18th

- 9.00-11.00 Obstetrics and Gynaecology—Dr. D. S. MacKay, Chairman.
 - (1) Obstructed Labour.
 - (2) Toxæmias of Pregnancy.
 - (3) Cancer of Cervix.
- 11.00-12.15 Small Group Clinical Demonstrations and Discussions.
- 12.30- 2.00 Lunch—Clinical Address.
- 2.30- 5.00 Medical Symposium—Dr. C. R. Gilmour.
- Evening Gordon Bell Memorial Lecture—Dr. Wm. Boyd, under auspices of the Winnipeg Medical Society.

‡ ‡ ‡ ‡

Saturday, May 19th

- 9.00-11.00 Diseases of Children—Dr. Gordon Chown and Dr. J. D. McEachern, Chairmen.
 - (1) The Acute Abdomen in Children.
 - (2) Pyuria in Childhood.
 - (3) Some Aspects of Tuberculosis in Childhood.
 - (4) The Acute Ear in Childhood.

‡ ‡ ‡ ‡

Meetings will be held in the Medical College unless otherwise specified.

Medical Library of the University of Manitoba

A summary of the contents of some of the journals available for practitioners, submitted by the Faculty of Medicine of the University of Manitoba. Compiled by T. E. HOLLAND, B.Sc., M.D. (Man.), F.R.C.S. (Edin.).

THE PRACTITIONER—September, 1933

This number contains a symposium on Birth Control, in which are the following articles:—

“Birth Control”—by Havelock Ellis.

“The Ethics of Birth Control”—by E. A. Barton, M.R.C.S., L.R.C.P.

“Is the Practice of Contraception Injurious to Health?”—by Eardley Holland, M.D., F.R.C.P., F.R.C.S., F.C.O.G., Obstetrical and Gynaecological Surgeon to the London Hospital.

“The Choice of a Contraceptive”—by C. P. Blacker, M.C., M.D., M.R.C.P., Honorary Secretary, Birth Control Investigation Committee.

“Contraceptive Methods”—by Cecil I. B. Voge, Ph.D., B.Sc., F.R.S.E.

—A description of a museum in the London School of Hygiene and Tropical Medicine.

“Birth Control in Practice”—by Edward F. Griffith, M.R.C.S., L.R.C.P., and Helena Wright, M.B., B.S.

“Notes from a Small Birth Control Centre”—by Alice L. L. Robson, M.B., C.M., D.P.H.

* * * *

THE CANADIAN MEDICAL ASSOCIATION JOURNAL—December, 1933

“Some Aspects of the Menopause”—by Beckwith Whitehouse, M.S., F.R.C.S., F.C.O.G., Professor of Gynaecology and Obstetrics, University of Birmingham.

—An address delivered before the Academy of Medicine, Toronto, October 14th, 1933. An excellent paper, dealing with the physiological, clinical and historical aspects of the subject.

“Evipan: A Preliminary Report on a New Intravenous Anæsthetic”—by Gavin Miller, M.D., Montreal.

—A report on 22 cases, covering a wide range of both major and minor surgery in which this drug was used by Dr. Miller.

“The Treatment of Diabetes in Children by Means of a Normal Type of Diet”—by Harry Medovy, B.A., M.D., Winnipeg.

From the Diabetic Clinic of the Winnipeg Children's Hospital and the Department of Pediatrics.

—Ten cases of diabetes in children are presented, showing the advantages of treatment by giving a normal diet for a normal child, and controlling any resultant glycosuria with insulin from the beginning of treatment.

“Tuberculous Peritonitis”—A report of 21 cases treated at St. Michael's Hospital, Toronto—by Harris McPhedran, M.B., F.R.C.P. (Can.), and George Peacock, M.D.

“Radiation in Carcinoma of the Cervix Uteri”—by William P. Healy, M.D., and John A. Kelly, M.D., Memorial Hospital, New York.

—A survey of cases treated during the years 1925 and 1926.

“Nasal Sinusitis as it Presents Itself to the General Practitioner”—by L. DeV. Chipman, Saint John, N.B.

—Dr. Chipman points out how this prevalent disease is frequently overlooked, owing to absence of local symptoms, and how serious complications may ensue.

“The New Clinico-Pathological Museum of the University of Manitoba Medical School.

—An editorial comment, describing in glowing terms this achievement of Professor William Boyd. The Editor concludes the description as follows: “At this time of financial depression, under which the University of Manitoba has suffered much, it is good to learn that a member of her Medical Faculty, out of his own intellectual resources, has been able to render such a noble and noteworthy contribution to the teaching forces of that school.”

* * * *

THE EDINBURGH MEDICAL JOURNAL December, 1933

“Intracranial Aneurysms: Cerebral Arteriography: Surgical Treatment”—by Norman M. Dott, F.R.C.S. (Ed.).

—A very interesting article, replete with case reports revealing the extraordinary success Mr. Dott has had in dealing with recurrent hæmorrhages from intracranial aneurysms.

APPOINTMENTS FOR RECENT GRADUATES OF THE UNIVERSITY OF MANITOBA

Dr. C. F. Code and Dr. A. MacLean have been given three-year fellowships at the Mayo Institute at Rochester, Minnesota. Both gentlemen graduated last year from the University of Manitoba, and at present are on the resident staff of the Winnipeg General Hospital. Dr. Code will work in the Department of Experimental Medicine. Dr. MacLean, who is a son of Dr. James A. MacLean, President of the University of Manitoba, will work in the Department of Clinical Medicine.

OBITUARY

PROFESSOR SWALE VINCENT

Thomas Swale Vincent was born in Staffordshire, England, on May 24th, 1868, and died of cancer at St. Alban's, near London, on December 31st, 1933. He was educated at the King Edward Grammar School, Birmingham, and studied medicine first at the old Mason College (now the University of Birmingham), taking his M.R.C.S., L.R.C.P., and later, his M.B., London. His whole subsequent career was devoted to the study of Physiology and related sciences. He commenced research work under Schafer (now Sir Edward Sharpey-Schafer) in University College, London, as holder of the Sharpey Scholarship, in 1890. Between 1890 and 1902 he acted at various times as Senior Demonstrator and Assistant Professor of Physiology at University College, London, and Lecturer in Physiology in University College, Cardiff, also spending a short time at Heidelberg, doing research under Kossel. During 1902-4 he held a Research Fellowship in the University of Edinburgh, again under Schafer, obtaining his D.Sc. from that University in 1904, and his M.D. London, in 1907.

In 1904 he was appointed Professor of Physiology in the University of Manitoba (also teaching Zoology until 1910), and held that appointment until 1920, when he accepted the Chair of Physiology in the Middlesex Hospital Medical School, a post carrying with it a Professorship in the University of London. From this Chair he retired in 1930.

As a student of Schafer he naturally became interested in the study of endocrinology, and for well over 30 years published a constant succession of papers dealing especially with the adrenals, pituitary, thyroid, islets of Langerhans, and ovaries. Perhaps his most successful work consisted of his studies in the comparative anatomy, histology, and physiology of certain of these glands, while his abiding claim to remembrance as an endocrinologist lies in his sound critical outlook on the whole subject during a period when endocrinology, especially in its clinical aspects, tended to run extremely wild. His sound judgment is mirrored in his *Internal Secretion and the Ductless Glands*, first published by Arnold in 1912, later editions appearing in 1922 and 1924. He also published an interesting monograph on *Secretion* in 1924.

He was elected a Fellow of the Royal Societies of Edinburgh and Canada, received the LL.D. degree from the University of Manitoba in 1920, was Ingleby Lecturer of the University of Birmingham in 1921, and Arris and Gale Lecturer of the Royal College of Surgeons in 1922.

His personality was vivid and not infrequently aggressive. He made many fast friends and some life-long enemies. His teaching was dominated by his passion for research; as a result many of his students received inspiration to become research-workers also.

The University of Manitoba owes him a perpetual debt. A small band of five scientists was appointed in 1904 to teach subjects for which the affiliated denominational colleges could not afford the funds. Prior to this time the University itself had been merely an examining body. This select scientific nucleus of the University could probably have benefitted their departments and themselves more, financially, had they been content to have remained a little science coterie, but they pressed steadily and successfully, against marked opposition, for the establishment of a true University, teaching all subjects independently of the denominational colleges. In this movement Vincent took a large share.

He was passionately fond of music, and a brilliant amateur pianist. In this, as in most of his interests, the research aspect was never forgotten, and he published some papers on the physiological effects of music.

He is survived by his widow (née Beatrice Overton) and two daughters. —A. T. C.

* * * *

DR. FREDERICK G. BRIEN

Dr. Frederick Graham Brien, of Elphinstone, Manitoba, died on December 30, 1933, in the Winnipeg General Hospital, after a brief illness, at the age of 71 years. He was born in Lindsay, Ontario, and attended school there and later the Normal School at Ottawa. He came West as a young man and was principal of schools at Birtle and Selkirk. He then took up the study of medicine and graduated in 1894 from the Manitoba Medical College. He practised at Dugald, Douglas and Winnipeg, Kerrobert, Sask., and Peachland, B.C., and lastly at Elphinstone.

Studious by nature and a sound classical student, Dr. Brien bore the reputation among his friends of being one of the best-read men in the province, though his modesty and unassuming nature prevented a wider recognition of his gifts. He was a sound practitioner and a delightful companion.

For true happiness there must be a deep and abiding reconciliation with circumstances.

—Sir Robertson Nicoll.

Medical Services for Citizens in Receipt of Unemployment Relief Funds

ESTIMATE OF COST IN MANITOBA

Previous to the recent Dominion-Provincial Conference at Ottawa, the Premier of Manitoba, the Honourable Mr. John Bracken, asked the committee of the Winnipeg Medical Society and the Manitoba Medical Association to submit a plan for the provision of medical services to citizens "on relief." It was pointed out that a plan had already been submitted. However, a letter was submitted, containing an estimate of the costs of medical services for the unemployed "on relief," and also for citizens in the rural districts who are not officially in receipt of relief funds, but who are unable to make provision for medical services. It is understood that this information was asked for with a view to using it in the conversations with the Dominion Government at Ottawa. Up to the time of going to press, no notification has been received by the committee as to the result of any deliberations at the conference. A meeting of the medical profession of Greater Winnipeg was arranged for January 26th, at which a decision as to what further steps were necessary was to be made.

The following is a copy of the letter to the Premier:

[Copy]

January 13th, 1934.

The Honourable John Bracken,
Premier of the Province of Manitoba,
Legislative Building,
Winnipeg, Manitoba.

Sir,—

With the desire of rendering to you the fullest possible assistance of the medical profession in your endeavor to supply medical relief for the citizens of Manitoba in need of medical attention and unable to pay for it, the committee representing the Winnipeg Medical Society and the Manitoba Medical Association beg to submit the following data:

1. The approximate number of citizens of this Province in receipt of direct relief, as at November 30th, 1933, was 73,000.
2. It is estimated there are approximately 25,000 citizens in the rural districts of the Province, who are not in receipt of relief, but are unable to pay for medical services when required.
3. These two classes, numbering altogether 98,000 citizens, present the urgent problem at the present time.
4. It is estimated that a complete medical and surgical service, paid for on the following scale of fees, could be supplied these citizens for approximately \$1.75 per person per annum, or approximately \$171,500.

| | |
|--|---------|
| Visit in the home..... | \$ 1.50 |
| Consultation in the Office..... | 1.00 |
| Visit in the Hospital..... | .75 |
| Maternity Cases Attended in the Home | 20.00 |
| Maternity Cases Attended in Hospital | 10.00 |
| All Surgical Operations—two-thirds (%) | |
| of present Workmen's Compensation | |
| Board Scale. | |

No fee for a surgical operation in any case to exceed \$50.00.

Mileage to be paid for at the rate of 25c per mile each way. This applies only to rural municipalities.

There shall be a limit of \$100.00 per month paid to any one doctor, except in areas or districts where it can be shown that almost the entire practice of a doctor consists of persons on relief, or indigents. In such cases, payments not to exceed \$150.00 in any one month may be made.

5. It is pointed out that the "Municipal Doctor" plan, as operated in this Province, costs the Municipality \$2.70 per head of population.

6. Should the suggested scheme of medical relief become operative, there is reason to anticipate a marked decrease in hospitalization, with its coincident expense.

7. The medical profession is prepared to co-operate with the Government of the Province in the fullest degree.

There are, of course, many further details which would have to be arranged should the general principles of this scheme be accepted, but it does not appear necessary to introduce them at this stage. This project would provide medical and surgical service to the unemployed individual by a doctor of his own choice. It would be accepted by the medical profession as a temporary measure during this period of financial stringency. It would furnish a medical service at a figure considerably lower than that of the National Health Insurance Plan of Great Britain.

It is not necessary for us to raise the question that the medical profession is laboring under an unfair burden. You have yourself expressed that sentiment in public. We must, however, reiterate the statement that the care of the health of the population is the responsibility of governments, and not of the medical profession.

Submitted on behalf of the joint committee of the Winnipeg Medical Society and the Manitoba Medical Association, we have the honor to be, Sir,

Your obedient servants,

(Signed) E. S. MOORHEAD,
Chairman of Committee.

(Signed) A. J. SWAN,
Secretary of Committee.

Medical Economics

(From the Canadian Medical Association Journal)

THE ECONOMIC SITUATION IN SASKATCHEWAN

Most of the cities of Saskatchewan have conceded the right of the doctor to be paid for work done on relief cases. The city of Regina voted \$20,000.00 in the 1932 budget. Some doctors do not render any accounts to the city. The highest amount paid to any one doctor in 1932 was \$966.00. The city pays \$1.50 for each house call on an indigent. The Medical Health Officer must be notified after the first visit and must sanction the doctor's attendance. Twenty dollars is paid for a maternity case in the home; ten dollars for one in the hospital. Operations and serious illnesses in the hospital are paid for at partial schedule fees, not more than fifty dollars being paid for any one case. The city pays nothing for office visits. Surgical operations must be emergencies; no indigent patient is admitted to the hospital for treatment of a chronic condition. Nothing is paid for tonsillectomies or for examining eyes for glasses. The eye, ear, nose and throat specialists are paid only for emergency mastoid operations and acute antrum operations.

In Saskatoon the doctor, after the first visit, reports the case to the Medical Health Officer. If the patient is indigent and needs medical care the doctor is given an order requesting him to render treatment, signed by the mayor, the Medical Health Officer and the inspector. After the doctor receives this order he must render his bill for services rendered, except in surgical and maternity cases, at the end of seven days from the date of the order, and every seven days thereafter so long as he attends the patient under the order. Surgical cases are paid for at the rate of 35 per cent. of the schedule of fees authorized by the College of Physicians and Surgeons of Saskatchewan, up to the maximum of \$50.00; for maternity cases in the home is paid \$17.50, and \$1.50 for house visits; medical and maternity cases in the hospital and office visits are not paid for. After the amount voted in the city estimates is spent, any doctor who has accepted an order requesting him to care for indigents agrees to continue caring for them, even if there is no money left to pay.

In Moose Jaw one doctor has been appointed to look after the indigents for \$200.00 a month: for operative cases they pay the assistant a small fee. They offered the specialists 35 per cent. of the rates laid down by the College of Physicians and Surgeons, but as the men doing special work felt entitled to 50 per cent., a settlement has not yet been reached. While the indigents are supposed to go to the city appointee for care, it is estimated that the medical men as a whole are

looking after well over 50 per cent. of the relief and indigent cases, because they like to look after their own old families, even if they have fallen on evil times.

In Weyburn \$600.00 is divided equally among the four doctors there for care of any indigents who may present himself. About 600 people are on relief.

In Yorkton the doctors look after all the indigents for nothing, but the city does not ask any of them to pay a business tax. The business tax in Yorkton is about fourteen cents a square foot.

In North Battleford the city council pays nothing for treatment of indigents.

Reports from the country districts vary with the locality. Fifty-eight municipalities will need help. There are 562 organized municipalities in the province. The area needing complete relief is along the southern border, extending farther west and north than last year and another region about half way between Regina and Saskatoon.

Crops in the north-east area are good, that is, in the districts around Yorkton, Canora and Pelly. They have never had a crop failure in that region.

In Grenfell, a town which is situated in the south-east area, the town council refuses to pay for indigents. Where possible the doctors send the patients to the hospital and the town pays the hospital bill. In the rural district around Grenfell there is a fair crop and plenty of feed, but the attitude of the people has changed toward their obligations; they seem intent on avoiding payments if possible.

In the north-west, around Kindersley district, there is a crop failure and collections are below 10 per cent. of the work done at the present time. Owing to poor tax-collection the municipalities are not in a position to undertake the payment of medical work, even if they were so inclined.

A letter from a clergyman in the northern area where the territory is unorganized gives the following information:—

"The settlers have paid so little in taxes that the Department of Municipal Affairs is not attempting to provide hospital or medical services. When they write to the Department of Public Health they are told that inasmuch as they are living in unorganized territory they should communicate with the Department of Municipal Affairs. However, in special cases the Department of Public Health will authorize expenditures. The local doctor received \$50.00 a month from December, 1932, to May, 1933. There are over 200 families on relief in an area served by only one doctor. No provision has been

made for the supply of drugs; the Relief Officer issued a few vouchers to cover necessary drugs, but he was informed by higher authorities that he had nothing to do with drugs. Conditions, in general are appalling. This is to be the hardest winter we have had."

City councils, in general, seem to take a fair and reasonable view of the doctor's work, but the rural municipal councils do not share these views. For the most part, now, they will pay a hospital bill, but paying the doctor is something they are not prepared to do. Any doctor is very foolish who proceeds with the treatment of an indigent case without authorization in writing from the secretary-treasurer of the municipality.

Patients are becoming increasingly irresponsible about looking after their own illnesses. Recently the public health nurse asked a patient in the home what plans she had made regarding her confinement, "My husband is going down to Dr. Coles (the M.H.O.) to see what he is going to do about it." The indigents expect the city to provide them with medical and nursing care for the yearly baby, to supply layettes, later on, clothing from the community clothing bureau, and in many cases are ready to complain about the quality of service given to them.

Premier Bennett met with the Premiers of the Prairie Provinces on October 19, in Regina. At this meeting he stated that responsibility for medical care remained with the provinces. So far no plans have been announced by the Provincial Relief Department.

THE FINANCIAL ASPECTS OF STATE HEALTH INSURANCE FOR ALBERTA

By G. E. LEARMONTH,
Calgary

Suggestions regarding possible systems of state health insurance have been made by the Commission appointed by the Legislature of Alberta to study the question. One provides for all the people of the province, at a cost of \$11,000,000 or \$13.75 per capita per year, and the other for working people only, at an annual cost of \$1,900,000 or \$13.17 per capita.

The first plan includes all the people of Alberta, 731,605, at an average morbidity of 7.35, or 5,377,296 days. At this latter figure the cost for hospitals is 66.83 cents or total of \$3,593,647, or \$4.91 per capita; 59.01 cents for drugs, \$729,699, \$0.99; 27.88 cents for dentists, \$1,499,190, \$2.05; total of \$8,995,678 or \$12.29 per capita.

Ten per cent, or \$899,567 is allowed for administration and 2 per cent or \$179,913 for contingency reserve, or a total of \$1,079,480 or \$1.45 for these two items; making a grand total of \$10,075,158 or \$13.75 per capita, per year, or \$1.15 per head per month.

On the basis of an employee paying five-ninths of the cost, this would amount to 64 cents per month, while an individual not an employee would pay seven-ninths, or 90 cents per month. The average number of dependent on one wage-earner's income is 2.4, but under present conditions it is estimated at from four to five dependents. The commission takes three as a fair average, so that an employee would pay three times 64 cents, or \$1.92, and an individual not an employee three times 90 cents, or \$2.70.

The second plan benefits only employees. The figures are based on that of June, 1931, when there were 142,090 wage earners in Alberta. This figure, at the average morbidity rate of 7.05 per capita, the average applying to ages from 15 to 69, would give 1,001,734 days.

Under this plan the costs would be: 1,001,734 days at 66.83 cents for hospitals, total of \$669,458 or \$4.70 per capita; 59.01 cents for doctors, \$591,123, \$4.16; 13.57 cents for drugs; \$135,935, \$0.95; 27.88 cents for dentists, \$279,283, \$1.96; total of \$1,675,799, or \$11.77. Administration charges would be \$167,580 and 2 per cent for contingency reserve \$33,516, or a total of \$201,096, or \$1.40, making a grand total of \$1,876,895 or \$13.17 per capita.

The cost distribution of this would be: State, paying two-ninths, hospitals \$148,768, doctors \$131,361, drugs \$30,208, dentists \$62,062, total of \$372,399. Employer, paying two-ninths, hospitals \$148,768, doctors \$131,361, drugs \$30,208, dentists \$62,062, total \$372,399. Employee, paying five-ninths, hospitals \$371,921, doctors \$328,402, drugs \$75,520, dentists \$155,160, total \$931,003. Cost to employee would be: Hospitals \$2.61, doctors \$2.31, drugs 53 cents, dentists \$1.09, total \$6.54, or 55 cents a month.

The Commission says the province would be relieved of the 50 per cent patient day hospital grant in the case of each insured employee, as provision has been made in the estimate for total hospital costs. Ten per cent of the population are in hospital for 12 days, on the average. The Government grant for this group would be \$85,000.

HEALTH INSURANCE

By G. E. LEARMONTH,
Calgary

The College of Physicians and Surgeons in Alberta has been taking a plebiscite of the profession on the question of health insurance, as it is expected that during the coming session of the legislature this subject will be brought forward, with the avowed intention, of placing every physician in this province under the jurisdiction of the Provincial Government. The following are some of the questions which have been asked:—

"Is the present system of practising medicine satisfactory: (a) to the patient? (b) to the physician?"

"Is an adequate medical service now available to all of the people?"

"Are the conditions of practice now satisfactory to the medical men: (a) financially? (b) do your patients consult you early enough? (c) could you do better work for your patients if they were not afraid of the expense?"

"If a mutually satisfactory system of health insurance was devised would you be in favour of it? If not, and if you are not satisfied with the present system, what would you suggest?"

"If a satisfactory system of state health insurance was set up: (a) should it be province wide and compulsory, that is, should it include all from the wealthy to the indigent class, inclusive? or only those in receipt of less than a stated annual income? (b) should the scheme include cash compensation for loss of time to the insured? (c) should the authority for control and the responsibility for payments to the profession be vested in a central board or handled by local boards in local areas?"

"Payment for services: do you favour the perpetuation of the principle of competitive practice, or the individual's right of choice of a doctor and the family physician type of practice, with provision for the reference of certain cases for consultation and specialized services; if so, in your opinion can these principles best be maintained by the "service-rendered" system of payment, that is a system whereby the doctor presents his accounts on an agreed schedule basis to a central board for payment? or would you favour a panel system, whereby individuals select the physician of their choice and register themselves and their families, under a physician's panel, with provision for changing from one panel to another, under certain circumstances? or would you favour a straight "state medicine" type of service, with all medical services provided and paid for directly under control of the State, the profession giving their services on a salary basis?"

"Should a local Board or a Central Board, or anyone else, have anything to say as to where any doctor under the scheme should be located or as to who should practise in any given locality?"

"Should doctors be allowed to pursue independent practice?"

"If physicians were placed on an adequate salary (a) would the high standard of work maintained by most doctors be maintained? (b) would it be more satisfactory to the physician? (c) is there danger of competitive bidding by physicians for salary contract? (d) what pro-

visions would be made for permanent records of cases that would be available in case there was a change in resident physicians? (e) is there a possibility that the practice of medicine and care of the sick would become hampered by bureaucratic control?"

While the results are not finally known it would appear that from experience most men are convinced that anything which would interfere with the relationship that exists between the profession and the patient should not be disturbed, nor should the patient be hampered in his choice of physician where a choice is available.

To create a civil service for the medical profession, with a definite fixed salary, tends to minimize the desire of the members to do their best, as of necessity promotions would not be rapid and salaries could not be made to vary in towns of similar population, regardless of the effort put forth by an individual physician. The majority of physicians, according to the answers, prefer remuneration fixed on the service-rendered basis, because the greater the efficiency, the greater the remuneration, because the greater the practice. The replies show that emphasis is placed upon this, that, whatever changed condition follows, there should be no compensation for loss of time through illness of the patient, as malingerers might find it profitable to feign illness, which would make the financial burden unbearable to the province.

Though the present system is falling down at the present time, since patients are not attempting to pay their physicians in many cases, yet this is ascribed to the general depression and the further fact that though the province has placed the burden on the municipalities to care for their indigents, there is no real attempt to carry out the letter or the spirit of the Act. The Government will not force them to do so, and most of them will not pay without being forced. It is not felt that the present system is at fault or would be found to be so, were financial conditions at all like they were a few years ago. On the other hand, a feeling is expressed in the answers, that some system should be devised which would induce the improvident to save systematically, and thus they would not be charges on the community in times such as these. This might be done by a compulsory deduction from their wages or other earnings, and thus some type of insurance might be provided for them.

If any scheme is adopted, the physicians think there should be one central Board of Control and not a local committee or a panel system, but perhaps a card system, whereby any patient could go to the doctor of his choice, obtain the necessary service and the Central Board be called on to pay the physician at a rate agreed upon between the Provincial Government and the physician.

THE MEDICAL TREATMENT OF THE INDIGENT IN BRITISH COLUMBIA

By J. H. MACDERMOT, M.D.,
Vancouver

THE SITUATION

The problems caused by the depression as it affects this province are probably different only in degree from those faced by the profession in the other provinces of Canada. The more or less sudden and complete stoppage of income in some twenty thousand families has led to a situation where any medical relief afforded to the members of these families must be afforded on a basis of charity. The State has recognized its duty to feed and house these victims of social dysfunction; it has not yet accepted with any grace the idea that it has any responsibility towards them when they are sick. This is no new thing; the State has for many years refused to include in its allowances for old-age pensioners, receivers of Mothers' Pensions, etc., any sum for medical care by physicians. This does not mean, of course, that the State refuses to afford hospital care when necessary and nursing; but it fights vigorously against any suggestion that care by a physician should also be provided at the expense of the taxpayer. Only when forced to provide it, will it do so, and any payments it makes are on a minimum scale. When we speak of the State, in this regard, we imply the larger organisms of the Province or Dominion.

The indigent of the community may be divided into those receiving relief, *vis.*, the twenty or more thousand families referred to, and those who are still working, but, with the greatly reduced incomes now in vogue are quite unable to budget for medical care. For the former some relief is obtainable from the State; for the latter, none.

The province is divided into "organized" and "unorganized" districts, the former including the larger cities, *e.g.*, Vancouver, Victoria, New Westminster, Nanaimo, etc. Small villages and towns, rural districts, logging and mining areas come under the latter term. In the organized districts, Dominion and Province assume no responsibility for people who are resident there, for the unorganized districts and for the transients of no fixed abode, who are caught in the cities, some degree of medical care is provided. Any medical care provided by the authorities, it must be stated, applies only to those "on relief", not to the other equally needy people referred to.

In the unorganized districts there are two ways, roughly, in which provision is made for medical care. Local doctors are used to some extent, and a certain amount is paid for their work. On the whole, perhaps, this is not ungenerous, in view of the undoubted scarcity of funds. The second method is where the indigent are

collected in relief camps, for reasons of administrative economy, and here medical men are employed on a salary. The salary is quite inadequate as a rule, and is the smallest that will be accepted, but at least it keeps some medical man alive.

But in the cities or organized districts, conditions are entirely different, and it must be remembered that a good deal more than half the population of British Columbia is in these districts and the greatest amount of indigence is here, too, since the cessation of manufacturing, fishing, and of industry, generally, is felt most in the cities. Here the entire burden of medical care is thrown on the city or municipality, with the exception of the allowance always made by the Province for hospital care. The municipalities are frankly up against it; they cannot get the money. Taxes are desperately hard to get, and so much is ear-marked for relief that there is no money for road or street work, and so unemployment increases further—a vicious circle is formed. And, of course, there is no money for medical care.

The medical man, especially when he lives in the suburbs, is at a terrible pass. His income has gone to vanishing-point, because the people in his district are mainly out of work and on relief. But they used to be his patients and still call him in. He has to use his car and his time and his supplies, with no chance or hope of payment, and if hospital care is needed he loses the patient altogether, since our hospital authorities insist on such a patient going under the staff. The result is an enormous increase in unpaid hospital bills, and the hospitals are crying for relief. The staffs have reached the breaking-point and are beginning to rebel and refuse to carry on.

The city has provided two medical men to carry on work among the indigent. Needless to say, they cannot begin to handle even the emergency work. No provision is made for night work, and the city has simply left it to the private practitioner to carry on without pay.

This briefly is the situation that exists and that needs remedy. It is probably descriptive of the conditions everywhere in Canada.

WHAT THE MEDICAL PROFESSION HAS DONE

For nearly a year, we have, in Vancouver and in Victoria, been endeavoring to make arrangements with the city whereby the medical man might receive some return, even if a most inadequate one, for his work. As things are at present the medical man is a taxpayer, and pays his full share of the taxes out of which come relief funds. On top of this, he is expected to carry the whole load of medical care, except for two scandalously underpaid medical men on relief work. He has to pay for his own car expenses, office rent, dressings, etc., as well as give

his time free. We have pointed out the rank injustice of this. We have suggested that the money now spent, or rather wasted, on outdoor medical relief, be divided so far as it will go on any basis which will ensure protection of city funds, amongst the medical men outside, who will do the work in their offices.

We have met with the greatest courtesy and indeed sympathy from city officials. But *they have not the money*, they tell us, and they cannot get the Province or Dominion to help. So we have not yet succeeded in securing pay for our members, except in the matter of maternity cases. Here, where the doctor will and can confine a relief case at home, the money which would otherwise have gone to the hospital for two weeks' stay for mother and baby is paid to the doctor and nurse, so that the former gets about \$20.00, while the V.O.N. gets \$10.00. This is really quite a fair fee, as things go.

In Victoria, the maternity fee does not yet obtain, but the physician is asked to send in bills for his relief cases at ordinary rates, and up to not more than \$10.00 a month the city will pay them. The relief problem is not so acute, on the whole, in Victoria.

In North Vancouver, where there are very few medical men, and no hospital outdoor, conditions are somewhat better for the doctors. Here their bills are paid up to a reasonable amount, on the ordinary scale of fees.

In speaking of maternity cases, it is well to point out how quickly the habit of accepting charity grows in a community. Many of the relief cases refuse to be confined at home; they have a much better time in the hospital and a "specialist" to look after them. They have a holiday, good food, nursing, clean linen, and peace, and one can hardly blame them when one thinks of their ordinary conditions of living.

Another thing must be said to the credit of relief. Undernourishment and its consequences are not present to the degree that one might have expected amongst the families on relief. Their food is plain and wholesome, and the evils that some of us feared have not yet materialized.

There is a very strong feeling of resentment in the minds of medical men against the "professional fee" imposed on doctors by municipalities. This varies in amount in different municipalities, but to all of us it comes as an outrage. Not only are we paying other taxes, and bearing the cost of medical care of the indigent without any compensation, but we are further taxed an amount for which no return is given in any form. It is an iniquitous tax, and cannot, we think, be defended.

During the summer the profession in Vancouver decided, as from August 1st, to discontinue the care of relief cases in the Outdoor Department of the Vancouver General Hospital and elsewhere except in three cases:— (1) absolute emergencies where life is in danger; (2) where the patient has been an old family patient of the doctor in question, and he feels, for compassionate reasons, that he has to respond to the call; (3) where patients are sent to the Outdoor Department by a private physician for x-ray and other special examination. In this case, the outdoor staff will act. Every physician in the city signed an undertaking to act accordingly. A letter to this effect was also sent to the City Council. It is altogether probable that in the near future an even more drastic move will be made by the profession, which is considering whether it should entirely refuse to do even hospital or staff work for the indigent on relief. Such a move as this would undoubtedly bring matters to a head, but, it is hoped that it will not be necessary.

THE REMEDY

Some years ago, when employment was the normal and unemployment the abnormal, state health insurance was being carefully considered as a solution for the problems surrounding the question of medical care. A new condition exists, and it is very doubtful whether a contributory plan of health insurance is immediately feasible, or whether, if put into effect, it would meet the need existing.

We are not yet ready with any definite scheme in British Columbia, but the new Government has definitely committed itself to health insurance as a policy, and the new Minister of Education and Public Health, Prof. G. M. Weir, is particularly interested in this matter. It is altogether probable that within the next year or two some scheme will be devised *and put into effect*, dealing with this whole question of medical care in a comprehensive way. As anything materializes in this regard, we will keep the *Journal au fait* with developments.

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Without unceasing practice nothing can be done; practice is art. If you leave off you are lost.—*William Blake.*

Happiness is a perfume you cannot pour on others without getting a few drops on yourself.—*Emerson.*

NEWS ITEMS

from Department of Health and Public Welfare

SIMPLER PROCEDURE FOR DIPHTHERIA
PREVENTION

With the discovery of toxin-antitoxin a dozen or more years ago, there was created a powerful weapon in the fight against diphtheria. This splendid product has been used extensively and has played an important part in the nation-wide reduction in this disease. In recent years toxoid, another product, has been put to use and has largely replaced the earlier toxin-antitoxin. It has a number of advantages and in many places has been given in two doses instead of the three.

For some time thought and effort has been given to perfecting a product which would require but a single dose instead of two or three as now used with toxoid and toxin-antitoxin. It has been discovered that toxoid can be modified with alum in such a fashion as to give a product that will immunize against diphtheria in one dose instead of two or three.

This new alum toxoid has already been used in thousands of children and the results are apparently satisfactory. The New Haven Health Department has received a limited supply and very shortly a number of children will have the chance of being immunized with one injection instead of three.

It is hoped that the success of this new one dose treatment will be substantiated. There are many advantages to the one dose treatment. It is much easier for the children themselves. It will relieve the parent of two-thirds of the task of taking the child to the physician. It will reduce the work of the physician or the school doctor two-thirds.

If this procedure is put into general use, an even greater per cent of our babies and small children should be immunized. It is hoped that more and more parents will be willing to take their babies to the private physicians for this protective measure.

* * * *

MATERNAL MORTALITY IN
NEW YORK CITY

BY RANSOM S. HOOKER, M.D.

The following is the first instalment of an article published in the *Health Examiner*. The final instalment will be published under "News Items" in next month's publication of the *Bulletin*.

The problems surrounding the mortality among women from causes, directly or indirectly, associ-

ated with child-bearing, have long been a matter of concern to the medical profession. The spectacular progress of the last years in the reduction of many death rates has not been paralleled by any drop in the rate of death from puerperal causes. This failure to show any improvement is the more significant when it is realized that modern obstetrics has evolved from a neglected and relatively insignificant department of medical practice to a highly specialized one demanding the attention of the best skill of the medical profession. This advance has failed to produce a decrease in the deaths. The conviction has been growing that this group of diseases, if subjected to intensive study and investigation, would yield the information which could be utilized to produce an improvement comparable to that in other fields of preventive medicine.

As far back as 1917, the Public Health Relations Committee of the New York Academy of Medicine began to interest itself in the problem of puerperal mortality.

Two preliminary studies led to the conviction that if an intensive study of each individual puerperal death in New York City, for a period of three years, were made, it would yield information which could be utilized to produce an improvement comparable to that in other fields of preventive medicine.

The Committee was convinced that it was of the greatest importance to have the investigation of the deaths in question, follow their occurrence as closely as possible, as much of the material is a matter of the memory of the individual who must supply the information. The co-operation of the Department of Health made it possible for this to be done.

The study was begun on January 1, 1930. The Obstetrical Society of New York provided a loan to start the work and the funds to carry out the full study were generously supplied by the Commonwealth Fund.

The Committee requested Drs. Benjamin P. Watson, John O. Polak, George W. Kosmak and Harry Aranow to act as an Obstetrical Advisory Committee. The death of Dr. Polak deprived the Committee of a most able and enthusiastic member. Dr. Charles A. Gordon was appointed to take Dr. Polak's place.

THE METHODS OF STUDY

Each week there was forwarded to us from the Registrar's Office of the Department of Health a photostatic copy of every death certifi-

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cate which carried a puerperal condition, whether primary or contributory, as cause of death, or which merely stated the existence of pregnancy. By this method, notifications of deaths were received from one to two weeks after their occurrence and the investigation took place within a month.

In obtaining the information, the physician who signed the death certificate was first sought. In those instances where the patient had been delivered by one physician and cared for by another, both were interviewed. In every instance the physician met the investigator cordially and gave active co-operation and assistance.

When all cases for a month had been completed, a meeting of the Obstetrical Advisory Committee was called to examine the cases and decide upon the actual cause of death and the preventability.

The establishment of the true cause of death, being prerequisite to the further study of the mortality, was the first consideration. In this task there was the data given on the death certificates, but such information was taken as the point of departure, to be accepted or not, as the study of the individual case warranted. Thus, in many instances, the investigation yielded information which established as the cause of death, some condition which could not be established from an examination of the death certificate. In

17.8 per cent of cases there were established diagnoses which differed from those of the Registrar's Office. The reason for this lies in the fact that in many, if not most of such certificates, there was either careless or deliberate omission of any mention of the actual cause of death, such as those certificates where cardiac failure or broncho-pneumonia was given as the cause, where, in reality, there was a puerperal sepsis. The percentage of error in septicemia was 29.2. Occasionally there was a totally erroneous cause of death given on the certificate.

It was felt that a determination of the proportion of the deaths in this series which could have been avoided was one of the most valuable objectives of the study. In judging whether or not the death was inevitable, the criterion was that of the best possible skill both in diagnosis and treatment which the community could make available. Furthermore, in forming the decision determination was made of the place where responsibility for such a preventable death should be lodged: on the attendant, whether physician or midwife, or on the patient herself. All cases were assigned to either preventable or non-preventable groups.

All the cases which were classified as preventable, were further studied to ascertain where, in the course of the patient's treatment, occurred the error which, in the opinion of the Committee, was primarily responsible for the death. It was

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found that the errors in those cases in which the attendant, either physician or midwife, had been held responsible, fell into two groups:

1. Those cases in which there had been an error in judgment, in which class were included instances of poor judgment in the recognition or treatment of complications of pregnancy; the wrong choice of operation for delivery; the performance of the proper operation, but without proper safeguards such as transfusion in the case of patient's bleeding from a ruptured ectopic pregnancy or placenta praevia; the failure of the attendant to recognize his own limitations, either in omitting to call a consultant or in performing an operation for which, in the opinion of the Committee, his training and experience did not qualify him.

2. Those cases in which there had been an error in technique, which group includes all cases in which the attendant was unable properly to perform the operation which was the correct choice, or in which there was an obvious breach in his aseptic technique or that of his assistants. Also included in this group were those cases in which improper administration or choice of anesthetic had been the actual cause of the fatal result.

Cases in which the patient has been held responsible showed two types of failure to meet the requirements for proper care, and were so grouped:

1. Those cases where the patient failed to obtain medical advice. In this group were included the cases in which either from ignorance or neglect, the patient failed to obtain proper care during the prenatal period or to call an attendant at the onset of labor or the development of strikingly abnormal symptoms.

2. Those cases in which the patient failed to co-operate with her attendant by neglecting or refusing to follow his advice for the proper regime during pregnancy, the treatment of abnormalities, or the management of delivery or the puerperium.

PREVENTABLE DEATHS

Out of all the deaths, 2,041 in number, 1,343 (65.8 per cent) were, in the judgment of the Advisory Committee, preventable. That number of women, *if they had had proper treatment and care, could and should have been brought safely through parturition.* In this connection it is significant to note that this is regarded by the Advisory Committee as a conservative figure for preventable deaths. In the full report published by the Commonwealth Fund,* the deaths are analyzed at length by preventability and cause of death.

The figures for the total number of cases where the responsibility was ascribed to the physician, in all 61.1 per cent of the preventable deaths, show an almost equal division between faults of judgment and faults of technique, 49.1 per cent and 50.9 per cent respectively. This appears to reveal a surprisingly high degree of actual technical incompetence. These cases show a tendency on the part of the attendants to under-rate the seriousness of obstetrical operations.

In the group of cases in which the responsibility was ascribed to the patient, 36.7 per cent were judged preventable deaths and of these 40.8 per cent were due to lack of co-operation and 59.2 per cent to failure to obtain suitable care.

It will be seen that 60 per cent of all the deaths which could have been avoided have been brought about by some incapacity in the attendant: incompetent judgment, lack of skill or careless inattention to the demands of the case. Some of these situations have arisen out of the fact that internes have been given too wide a field of independent activity; most are plainly the results of incompetence. Prevention in this field will mean increasing the respect of the physician for the gravity of obstetrical operations and educating him to a greater caution in attacking problems which are properly the field only of the highly trained obstetrician.

* "Maternal Mortality in New York City, 1930-1932." Report issued by New York Academy of Medicine Committee on Maternal Mortality. Published by the Commonwealth Fund.

† † † †

COMMUNICABLE DISEASES REPORTED

Urban and Rural : December, 1933

Occurring in the Municipalities of:—

Chickenpox: Total 379—Winnipeg 166, Brandon 23, St. James 11, Kildonan East 9, Fort Garry 8, Grandview Rural 7, Brooklands 6, Hamiota 5, Stonewall 3, Hamiota R. 2, St. Boniface 2, Dauphin T. 1, Ethelbert 1, Louise 1, Rockwood 1, St. Vital 1, The Pas 1 (late reported: November, Cypress North 131).

Whooping Cough: Total 200—Winnipeg 42, Dauphin T. 23, Dauphin R. 10, Woodlands 5, La Broquerie 3, Kildonan West 2, Brandon 1, Hanover 1, Portage C. 1, Roland 1, St. James 1, The Pas 1, Unorganized 1, Whitemouth 1 (late reported: October, The Pas 85; November, Birch River Unor. 15, Dauphin T. 6, Unorganized 1).

Scarlet Fever: Total 110—Winnipeg 26, Franklin 23, Roland 6, St. Boniface 6, Coldwell 4, Kildonan West 4, St. Vital 4, Dufferin 3, Kildonan East 3, Strathclair 3, Woodlands 3, Brandon 2, Cypress North 2, Gilbert Plains R. 2, Harrison 2, St. James 2, Unorganized 2, Argyle 1, Deloraine 1, Emerson 1, Macdonald 1, Montcalm 1, Ochre River 1, Pipestone 1, Rhineland 1, Rockwood 1, Springfield 1, Stonewall 1, Swan River R. 1, Transcona 1.

Diphtheria: Total 66—Winnipeg 26, Unorganized 7, Rhineland 5, Strathclair 4, St. Andrews 4, Kildonan East 2, Morden 2, St. Vital 2, Dauphin T. 1, Dauphin R. 1, Ellice 1, Hanover 1, Lorne 1, Louise 1, Norfolk S. 1, Springfield 1, Transcona 1 (late reported: November, Gilbert Plains 2, Dauphin R. 1, Rhineland 1, St. Andrews 1).

Measles: Total 24—Winnipeg 19, St. Boniface 3, Dauphin T. 1, Portage C. 1.

Tuberculosis: Total 24—Winnipeg 6, St. Paul East 5, Assiniboia 2, St. Andrews 2, Unorganized 2, Coldwell 1, Grey 1, Killarney T. 1, Miniota 1, Russell T. 1, Whitemouth 1, Woodworth 1.

Influenza: Total 13—Brandon 4, Winnipeg 2, Norfolk S. 1 (late reported: September, Oakland 2, Bifrost 1, Hanover 1, Mossey River 1, Lawrence Unorganized 1).

Trachoma: Total 13—Franklin 7, Unorganized 5, Roland 1.

Mumps: Total 11—Winnipeg 10, Brandon 1.

Diphtheria Carriers: Total 6—Winnipeg 6.

Erysipelas: Total 5—Winnipeg 3, Portage C. 1, Springfield 1.

Lethargic Encephalitis: Total 2—Lorne 1, Winnipeg 1.

Anterior Poliomyelitis: Total 1—Unorganized 1.

Neonatorum Ophthalmia: Total 1—Unorganized 1.

Puerperal Fever: Total 1—Lorne 1.

† † † †

DEATHS FROM ALL CAUSES IN MANITOBA

For Month of September, 1933

Urban—Cancer 23, Tuberculosis 10, Pneumonia (all forms) 5, Whooping Cough 2, Diphtheria 1, Influenza 1, Puerperal Fever 1, Scarlet Fever 1, Typhoid Fever 1, other causes under 1 year 15, all other causes 141, Stillbirths 19. Total 220.

Rural—Cancer 22, Tuberculosis 14, Pneumonia (all forms) 11, Influenza 6, Whooping Cough 2, Diphtheria 1, Puerperal 1, Typhoid Fever 1, other causes under 1 year 39, all other causes 144, Stillbirths 19. Total 260.

Indians—Tuberculosis 5, Pneumonia (all forms) 2, Influenza 1, other causes under 1 year 1, all other causes 1. Total 10.

Grand Total 490.

The Bulletin

The Executive of the Manitoba Medical Association decided some time ago that for financial reasons it was necessary to consider two alternative courses with regard to the publication of the BULLETIN. The first was to reduce the size of the BULLETIN, and curtail the number of copies in order to reduce the expenditure. The second alternative was to secure more

advertising and in this way increase the revenue to the point where the BULLETIN would be self-supporting, and in the near future produce a profit for the Association. A special editorial committee, after a preliminary report to the Executive, decided to secure the opinion and advice of Mr. Gordon E. Hunter, Vice-President of J. J. Gibbons Limited, advertising

agents. He recommended that the Association secure the services of a man experienced in advertising work. The committee secured the services of Mr. J. G. Whitley. The change in the size of the BULLETIN was suggested by Mr. Whitley in order to allow it to carry more advertisements. The change in the name of the publication was considered by the committee to be advisable in view of the functions which it is now performing. In addition to reports of the activities of the Association and the Department of Health and Public Welfare, and the collecting of data relating to Western Canadian medical history, the publication will continue the reviews of journals in the Medical Library, the descriptions of developments in medical economics, and also the new series of articles dealing briefly with the diagnosis and treatment of various clinical conditions.

—EDITOR.

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There is a vast difference in lens grinding. Dies must be kept true—the work must not be hurried, every detail must be carefully carried out to give the wearer of our lenses the greatest comfort and vision.

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All these things are very vital to your eye welfare, and are the result of many years of effort in the building up of our business.

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Every error under the sun seems to arise from thinking that you are right yourself because you are yourself, and other people wrong because they are not you. —T. Hardy.

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NOTICE TO PRACTITIONERS

Through the co-operation of the Medical Research Committee of the University of Manitoba and the College of Physicians and Surgeons of Manitoba, this test has now been made available to physicians throughout the province, and will be carried out at the Medical College.

Physicians requiring the test will please note the following instructions:—

Two ounces of a clean specimen of urine from the first morning sample of the patient should be transferred to a thoroughly clean bottle, corked with a new cork if possible (preferably not rubber), and sent immediately, addressed to Dr. A. T. Cameron, Department of Biochemistry, Medical College, Winnipeg. If such a sample is received during the morning the test can be started at once and the result will be available 48 hours after receipt.

If the specimen has to be sent through the mail, as soon as possible after the urine is voided and two ounces transferred to the bottle for transit, sufficient toluene should be added to form a layer one-quarter of an inch deep, and the bottle should be shaken thoroughly after corking. Samples taken in Winnipeg for immediate test need no preservative.

A name for identification should be given, and the provisional diagnosis stated (pregnancy, hydatidiform mole, chorionepithelioma, etc.). Any accompanying complications or toxic conditions should be mentioned, since in certain conditions the urine sometimes proves fatal to the test animal (preventing the obtaining of results) unless special precautions are taken.

The fee is five dollars (\$5.00) payable at par in Winnipeg, and this must be sent with the urine sample or the test cannot be undertaken. Cheques should be made payable to the Medical Research Committee, University of Manitoba.

(Signed) A. T. CAMERON,
 Secretary,
 Medical Research Committee.